

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/26/2012  
FORM APPROVED  
OMB NO. 0938-0391

45<sup>th</sup> 12/08/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445476	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/24/2012
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NAME OF PROVIDER OR SUPPLIER

ISLAND HOME PARK HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

1758 HILLWOOD DRIVE  
KNOXVILLE, TN 37920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure accurate quarterly Minimum Data Set (MDS) assessments for two (#45, #96) of thirty-five sampled residents.</p>	F 278	<p>This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.</p> <p><b>F278</b></p> <p>1. Minimum Data Set for Resident #45 was corrected by the MDS Coordinator on September 19, 2012 to reflect the limitation in range of motion.</p> <p>Minimum Data Set for Resident #96 was corrected by the MDS Coordinator on October 29, 2012 to reflect the fall which occurred on July 24, 2012.</p> <p>2. The Director of Nursing evaluated the Minimum Data Set for all residents for the last 30 days to assure accuracy. October 31- November 15, 2012.</p> <p>3. The MDS Coordinator was inserviced on October 29, 2012 by the Director of Nursing and Administrator regarding proper documentation on the Minimum Data Set.</p>	11/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]*

*[Signature]*

11/6/12

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  <b>ISLAND HOME PARK HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1758 HILLWOOD DRIVE KNOXVILLE, TN 37920</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 278	<p>Continued From page 1</p> <p>The findings included:</p> <p>Resident #45 was admitted to the facility on February 16, 2005, with diagnoses including Debility, Osteoporosis, Joint Pain, and Hypertension.</p> <p>Medical record review of the quarterly Minimum Data Sets (MDS) dated March 22, 2012, and June 21, 2012, revealed the resident had no cognitive impairment and had no limitations with range of motion.</p> <p>Observation on October 23, 2012, at 12:15 p.m., revealed the resident, in the resident's room, sitting in a wheelchair. Further observation revealed the resident had limited range of motion of the left arm and both lower extremities. Interview with the resident at this time confirmed a slight limitation in range of motion of the left shoulder/arm and both knees. Further interview confirmed "no changes in several years."</p> <p>Interview with the Director of Nursing, in the conference room, on October 23, 2012, at 12:20 p.m., confirmed the MDS dated March 22, 2012, and June 21, 2012, did not reflect the limitation in range of motion.</p> <p>Resident #96 was admitted to the facility on July 21, 2012, with diagnoses including Dementia, Diabetes, Glaucoma, Blindness of One Eye, Psychosis, and Abnormal Loss of Weight.</p> <p>Medical record review of the quarterly Minimum Data Set dated July 28, 2012, revealed no documentation the resident had experienced a</p>	F 278	<p>4. The Director of Nursing and/or the Assistant Director of Nursing will review all MDSs weekly x 4 weeks, then monthly x 2 months for 20 residents and/or 100% compliance.</p> <p>Results obtained will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan.</p> <p>Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.</p>		

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F 278	Continued From page 2 fall since admission.  Medical record review and review of facility documentation revealed the resident sustained a fall from the wheelchair, without injury on July 24, 2012.  Interview with the Director of Nursing, in the conference room, on October 23, 2012, at 12:20 p.m., confirmed the MDS dated July 28, 2012, did not reflect the resident's fall on July 24, 2012.	F 278			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by:	F 280	<b>F280</b> 1. The Care Plan for Resident #24 was revised by the Care Plan Coordinator on October 24, 2012 to reflect interventions for the October 18, 2012 fall.  2. The Director of Nursing evaluated care plans of all residents with falls in the past 3 months for accuracy October 31, 2012. No other residents' care plans were found to be affected.  3. The Care Plan Coordinator and licensed nurses were inserviced on October 29- November 7, 2012 by the Director of Nursing, Assistant Director of Nursing and Administrator on revising care plans to reflect fall interventions.  4. The Director of Nursing, Assistant Director of Nursing and/or the charge nurse will review Care Plan revisions related to falls daily for one week, 1 x week for 3 weeks then 1 x monthly for 2 months and/or 100% compliance.  Results obtained will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations.	11/15/12	

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F 280	<p>Continued From page 3</p> <p>Based on medical record review, observation, and interview, the facility failed to revise a care plan related to falls for one resident (#24) of three residents reviewed of thirty-five sampled residents.</p> <p>The findings included:</p> <p>Resident #24 was admitted to the facility on September 22, 2008, with diagnoses including Muscle Disuse Atrophy, Osteoarthritis, Psychosis, Vascular Dementia, Congestive Heart Failure, Cerebral Vascular Accident and Insulin Dependent Diabetes Mellitus.</p> <p>Medical record review of the annual Minimum Data Set (MDS), dated July 25, 2012, revealed the resident was cognitively impaired and required assistance with activities of daily living.</p> <p>Medical record review of the resident's Care Plan revealed the resident experienced a fall October 18, 2012.</p> <p>Review of a facility investigation report, dated October 18, 2012, at 8:25 a.m., revealed "...while CNA (certified Nurse Assistant) assisting with sitting up breakfast tray resident began scooting and slid out of the bed, able to move extremities, denies pain...Immediate Post incident Action ...(1) up in w/c (wheelchair) for meals..."</p> <p>Review of the resident's Care Plan on October 24, 2012, revealed no intervention for the October 18, 2012, fall as indicated on the facility investigation report.</p> <p>Observation on October 24, 2012 at 8:15 a.m., in</p>	F 280	<p>This committee will determine if any revisions are needed to the audit plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.</p>		

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F 280	Continued From page 4 the resident's room, revealed CNA #1 setting up the resident's breakfast tray and placed the bedside table at the resident's bedside. Further observation revealed the CNA did assist the resident up in the wheel chair.  Interview with CNA #1 on October 24, 2012, at 8:30 a.m., in the hallway outside the resident's room, revealed "...would normally get the resident up in the wheel chair...did not do it this morning because...running behind..."  Interview with the Director of Nursing and the facility Administrator, on October 24, 2012, at 8:40 a.m., at the nurse's station, confirmed the Care Plan was not revised related to getting the resident up in a wheel chair for meals.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to follow physician's orders related to a psychiatric follow up visit for one resident (#64) of ten residents of thirty-five sampled residents.  The findings included:	F 309	<b>F309</b> 1. Resident #64 was assessed by the Director of Nursing on October 23, 2012 and found to have no adverse effects. The Director of Nursing notified the physician and the responsible party on October 23, 2012.  The psychiatric follow-up on Resident #64 was completed on October 27, 2012. No new orders were noted.  2. The Director of Nursing evaluated all Physician Orders from the past 3 months for requested psychiatric follow-up October 31- November 2, 2012. No other residents were found to be affected.	11/15/12	

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F 309	Continued From page 5  Resident #64 was admitted to the facility on April 20, 2012, with diagnoses including Fractured Femur, Herpes Zoster, Hypertension, Hyperlipidemia, Leukocytosis and Bacterial Infection.  Medical record review of the quarterly Minimum Data Set (MDS), dated July 15, 2012, revealed the resident was cognitively impaired and required assistance with activities of daily living.  Medical record review of a Physicians Order dated September 17, 2012, revealed "...Depakote Sprinkles (mood stabilizing medication) 125 mg (milligrams) BID (two times a day) and ask Psych (psychiatric) to follow up for agitation..."  Observation on October 23, 2012, at 9:30 a.m., in the front entrance of the facility, revealed the resident sitting in the wheelchair watching television.  Interview with the Director of Nursing (DON) on October 23, 2012, at 12:55 p.m., in the conference room, confirmed the psychiatric follow up (ordered on September 17, 2012) had not been completed by the facility.	F 309	3. All licensed nurses were inserviced by the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator on October 23-November 2, 2012 regarding following physician's orders related to a psychiatric followup visit.  4. The Director of Nursing, Assistant Director of Nursing and/or charge nurse will review Physician Orders related to a psychiatric follow up visit daily for one week, then 3 x weekly for 3 weeks. Then 1 x weekly for 2 months and/or 100% compliance.  Compliance results will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F323	F323 1. Resident #24 was placed in wheelchair by Certified Nurse Assistant on October 24, 2012. Certified Nurse Assistant was inserviced by the Director of Nursing on October 24, 2012.	11/15/12	

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F 323	Continued From page 6  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure safety measures were in place related to a fall for one resident (#24) of three residents reviewed of thirty-five sampled residents.  The findings included:  Resident #24 was admitted to the facility on September 22, 2008, with diagnoses including Muscle Disuse Atrophy, Osteoarthritis, Psychosis, Vascular Dementia, Congestive Heart Failure, Cerebral Vascular Accident and Insulin Dependent Diabetes Mellitus.  Medical record review of the annual Minimum Data Set (MDS), dated July 25, 2012, revealed the resident was cognitively impaired and required assistance with activities of daily living.  Review of a facility investigation report, dated October 18, 2012, at 8:25 a.m., revealed "...while CNA (Certified Nurse Assistant) assisting with sitting up breakfast tray resident began scooting and slid out of the bed, able to move extremities, denies pain...Immediate Post Incident Action ...(1) up in w/c (wheelchair) for meals..."  Observation on October 24, 2012 at 8:15 a.m., in the resident's room, revealed CNA #1 setting up the resident's breakfast tray and placed the bedside table at the resident's bedside. Further observation revealed the CNA did assist the resident up in the wheel chair.	F 323	Resident #24 was assessed by the Director of Nursing on October 24, 2012 and found to have no adverse effects. The Director of Nursing notified the physician and the responsible party on October 24.  2. Facility investigation reports of all residents with falls in the past 3 months were evaluated by the Director of Nursing on October 31, 2012 to determine if implemented safety measures were in place. No other residents were found to be affected.  3. All Certified Nursing Assistants and licensed nurses were inserviced by the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator on October 24 – November 7, 2012 regarding following safety measures identified for residents.  4. The Director of Nursing, Assistant Director of Nursing and/or charge nurse will review each investigative report to assure identified safety measures are in place daily for one week, then 3 x weekly for 3 weeks. Then 1 x weekly for 2 months and/or 100% compliance.  Compliance results will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan.		

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F 323	Continued From page 7  Interview with CNA #1 on October 24, 2012, at 8:30 a.m., in the hallway outside the resident's room, revealed "...would normally get the resident up in the wheel chair...did not do it this morning because...running behind..."  Interview with the Director of Nursing (DON) and the facility administrator on October 24, 2012, at 8:50 a.m., at the nurse's station, confirmed the resident was not placed in a wheel chair prior to eating and the facility failed to ensure safety measures were in place.	F 323	Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility staff failed to ensure one resident (#81) received tube feeding as ordered of three residents reviewed of thirty-five sampled residents.  The findings included:	F 325	F325 1. The Glucerna 1.2 tube feeding of Resident #81 was adjusted by the Charge Nurse on October 23, 2012 to infuse at 40 ml per hour via the tube feeding pump per physician order.  Resident #81 was assessed by the Director of Nursing on October 23, 2012 and found to have no adverse effects. The Director of Nursing notified the physician and the responsible party on October 23, 2012.  2. The Director of Nursing evaluated all tube feeding pumps on October 23, 2012 to assure ordered infusion rates were being followed. No other residents were found to be affected.  3. All licensed nurses were inserviced by the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator on October 24 - November 2, 2012 regarding proper monitoring of infusion rates on tube feeding pumps.	11/15/12	

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F 325	Continued From page 8  Resident #81 was admitted to the facility on September 19, 2012, and readmitted on October 16, 2012, with diagnoses including Urinary Tract Infection, Dysphagia, Bacterial Pneumonia, Heart Failure, Hypertension, Diabetes, Chronic Kidney Disease, Esophageal Reflux, and Gout.  Medical record review of a Physician's Order dated October 16, 2012, revealed the resident was to receive Glucerna 1.2 at a rate of 40 ml (milliliter) per hour by tube feeding.  Observation on October 22, 2012, at 11:58 a.m., revealed the resident lying on the bed, with Glucerna 1.2 infusing at 30 ml an hour via a tube feeding pump. Observation on October 23, 2012, at 10:30 a.m., and 12:15 p.m., revealed the resident lying on the bed receiving Glucerna 1.2 at 30 ml per hour.  Observation and interview on October 23, 2012, at 12:30 p.m., with Registered Nurse #2, in the resident's room, revealed the resident lying on the bed receiving Glucerna 1.2 at 30 ml per hour and confirmed the resident was not receiving the Glucerna 1.2 at 40 ml per hour as ordered by the physician.	F 325	4. The Director of Nursing, Assistant Director of Nursing and/or Charge Nurse will evaluate all tube feeding pumps for proper infusion rate daily for one week, then 3 x weekly for 3 weeks. Then 1 x weekly for 2 months and/or 100% compliance.  Results obtained will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	F 333	F333 1. Resident #76 was assessed by the Director of Nursing on October 22, 2012 and found to have no adverse affects. The Charge Nurse notified the physician of the medication error on October 22, 2012; no new orders were given.  The Charge Nurse notified the Pharmacy and responsible party on October 22, 2012.	11/15/12	

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F 333	<p>Continued From page 9</p> <p>and interview, the facility failed to prevent a significant medication error for one resident (#76) of ten sampled residents.</p> <p>The findings included:</p> <p>Resident #76 was admitted to the facility on February 18, 2009, with diagnoses including Diabetes, Cerebrovascular Disease, Convulsions, and Hypertension.</p> <p>Medical record review of the Physician's Recapitulation Orders dated October 1, 2012, through October 31, 2012, revealed "...Dilantin (antiseizure medication) 100 mg (milligrams)...take 2 capsules...by mouth every morning...Calcium 600 (mg) (with) D 400 IU (international units) take 1 tablet by mouth 2 times daily..."</p> <p>Medical record review of a Consultant Pharmacist Communication to the Physician form dated October 2012 revealed "...a drug interaction between Dilantin and Calcium has been noted. The use of these two medications together may cause decrease Dilantin absorption...dose Calcium 1 hour before or 2 hours after dilantin..."</p> <p>Medical record review of a Physician's Order dated October 17, 2012, revealed "...Dose Ca (calcium) 1 (hour) before or 2 (hours) after dilantin..."</p> <p>Observation on October 22, 2012, at 8:20 a.m., in the resident's room, revealed Registered Nurse #1 administered Dilantin 100 mg 2 tablets and Calcium 600 mg with D 400 International Units, to resident #76.</p>	F 333	<p>2. The Regional Director of Clinical Services evaluated all Medication Administration Records on October 22, 2012 for residents receiving Dilantin and Calcium to assure physician orders are being followed. No other residents were found to be affected.</p> <p>3. All licensed nurses were inserviced by the Director of Nursing, Assistant Director of Nursing and/or the Staff Development Coordinator October 22 – November 2, 2012 on proper administration times of Dilantin and Calcium.</p> <p>4. The Director of Nursing and/or Assistant Director of Nursing will audit all Medication Administration Records of residents receiving Dilantin and Calcium daily for 1 week, then 3 times a week for 3 weeks. Then 1 x a week for 2 months and/or 100% compliance.</p> <p>Results obtained will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445476</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/24/2012</b>
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NAME OF PROVIDER OR SUPPLIER

**ISLAND HOME PARK HEALTH AND REHAB**

STREET ADDRESS, CITY, STATE, ZIP CODE

**1758 HILLWOOD DRIVE  
KNOXVILLE, TN 37920**

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F 333	Continued From page 10	F 333	Activity Director, Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	
F 371 SS=F	<p>Interview on October 22, 2012, at 8:30 a.m., in the hall, with Registered Nurse #1, confirmed the Dilantin and the Calcium were not to be administered together.</p> <p><b>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</b></p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store food products in a safe manner in the dietary department, timely discard leftovers in the dietary department, maintain and store pots and pans in a clean manner, and failed to ensure the appropriate temperature of food was maintained.</p> <p>The findings included: Observation and interview on October 22, 2012, at 7:35 a.m., with the Dietary Manager in the dietary area revealed cooked ham in the refrigerator was uncovered. Continued observation in the dry storage area revealed two bowls of Cheerios dated October 15, one bowl of Corn Flakes dated October 19, five bowls of Rice</p>	F 371	<p><b>F371</b> 1. The cooked ham was disposed of by the Dietary Manager on October 22, 2012.</p> <p>Two bowls of Cheerios, three bowls of Corn Flakes,, five bowls of Rice Krispies, one undated bag containing three hot dog buns and one undated bag containing 6 hot dog buns were disposed of by Dietary Manager on October 22, 2012. Five skim milks and four chocolate milks were disposed of by Dietary Manager on October 22, 2012.</p> <p>The can opener was cleaned by Dietary Manager on October 22, 2012.</p> <p>Eight two inch pans, two six inch pans, two muffin pans, two cake pans were cleaned or replaced by the Dietary Manager and Assistant Dietary Manager on October 22, 2012.</p> <p>The electrical cord was cleaned by the Director of Facilities Management on October 22, 2012.</p>	11/15/12

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F 371	<p>Continued From page 11</p> <p>Krispies were not dated, two bowls of Corn Flakes dated October 14, one bag containing three hot dog buns and one bag containing 6 hot dog buns inside no date on package. Continued observation in the refrigerator in the dietary area revealed five skim milks with the expiration date of October 21 and four chocolate milks with the expiration date of October 18.</p> <p>Interview with the Dietary Manager at the time of the observation confirmed prepared bowls of cereal were to be discarded after two days and confirmed that all food items are to be sealed with the date opened on the package and the expired foods were not discarded.</p> <p>Further observation on October 22, 2012, at 8:05 a.m., with the Dietary Manager in the dietary area revealed the can opener was dirty, eight of eight two inch pans soiled with debris dried on the inside of the pans, two of four six inch pans with dried debris on the inside, two of two muffin pans with a white crusty substance on the top of the pans, and two of eight cake pans had debris dried on the inside of the pans. Continued observation revealed an electrical cord over the food preparation area dirty and a meat slicer with white debris smeared on blade.</p> <p>Interview with the Dietary Manager at the time of observation, confirmed the pans, can opener, electrical cord and the meat slicer were not clean.</p> <p>Observation and interview on October 22, 2012, at 11:55 a.m., at the buffet serving line in the dining room with the Dietary Manager revealed pureed meat at a temperature of 112 degrees Fahrenheit, and milk at the temperature of 44.3</p>	F 371	<p>The meat slicer was cleaned by the Dietary Manager on October 22, 2012.</p> <p>The pureed meat on the buffet serving line in Dining Room was heated to temperature by Dietary Manager prior to serving on October 22, 2012.</p> <p>The milk at the temperature of 44.3 degrees Fahrenheit was replaced by the Dietary Manager prior to serving with milk held below 41 degrees Fahrenheit on October 22, 2012.</p> <p>2. All food items stored in refrigerators and stock room were evaluated by the Dietary Manager to assure all items were covered and dated on October 22, 2012. No other items were found to be affected.</p> <p>All milk cartons were evaluated by Dietary Manager and Assistant Dietary Manager to assure stamped dates were current on October 22, 2012.</p> <p>All food items on the buffet serving line were checked for proper holding temperatures for hot foods above 135 degrees Fahrenheit and cold foods held below 41 degrees Fahrenheit. No other food times were found to be affected.</p>	

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		F 371	<p>3. All Dietary employees were inserviced by the Dietary Manager on the cleaning schedule, proper storage of food products in a safe manner, timely discarding of leftovers, maintaining and storing of pots and pans in a clean manner, and ensuring appropriate temperature of food on October 22-November 2, 2012.</p> <p>4. The Dietary Manager, Assistant Dietary Manager or Cook will audit stock room and refrigerators for properly covered and dated food items daily for 1 week, then 1 x a week for 3 weeks. Then 1 x week for 2 months and/or 100% compliance.</p> <p>The Dietary Manager, Assistant Dietary Manager or Cook will evaluate all milk storage areas daily for 1 week, then 1 x a week for 3 weeks. Then 1 x week for 2 months and/or 100% compliance to assure milk is within serving dates and proper serving temperature.</p> <p>The Dietary Manager, Assistant Dietary Manager or Cook will evaluate the can opener and electrical cord for cleanliness daily for 1 week, then 1 x a week for 3 weeks. Then 1 x week for 2 months and/or 100% compliance.</p> <p>The Dietary Manager, Assistant Dietary Manager or Cook will evaluate food temperatures prior to serving each meal to assure proper holding temperatures of food and beverage items.</p>	

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F 371	Continued From page 12 degrees Fahrenheit.  Interview with the Dietary Manager at the time of observation confirmed holding temperatures for hot foods should be above 135 degrees Fahrenheit and cold foods should be held below 41 degrees Fahrenheit. Continued interview with the Dietary Manager confirmed the facility failed to serve food at a safe temperature.	F 371	Results obtained will be reported by the Dietary Manager to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.		
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain two dumpsters in good condition, and properly dispose of garbage.  The findings included:  Observation and interview on October 23, 2012, at 9:15 a.m., behind the facility with the Dietary Manager revealed two dumpsters (dumpster #1 on left side, dumpster #2 on the right side) side by side, with thick white liquid substance coming from both dumpsters. Continued observation revealed dumpster #1 had rusted holes in the bottom, and dumpster #2 had a foot long rusted hole near the bottom right side and numerous holes rusted in the bottom. Continued observation revealed slices of bread and other food debris lying on the ground around the dumpster.	F372	F372 1. The liquid substance and food debris was removed from the ground around the dumpsters by the Facilities Management Director on October 23, 2012.  Dumpster #1 and dumpster #2 were replaced on October 29, 2012 by Emco Waste Management.  2. These are the only 2 dumpsters at the facility; no other dumpsters were affected.  3. Facilities Management Director and Facilities Management Assistant were inserviced on October 23, 2012 by the Administrator regarding maintaining the dumpsters in good condition and properly disposing of garbage.	11/15/12	

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F 372	Continued From page 13 Interview at the time of the observation, with the Dietary Manager confirmed the dumpsters were leaking and had holes in them, and food debris was on the ground around the dumpsters.	F 372	4. Dumpsters will be evaluated daily by Facilities Management Director, Assistant Facilities Management Director and/or Housekeeping Aide to assure debris is not on the ground and the containers are not leaking liquid substances. Immediate reporting to dumpster provider will result if equipment is found to be leaking.		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on medical record review, review of Pharmacist Communication forms, and interview, the facility failed to act upon pharmacy recommendations for two residents (#37, #11) of ten residents reviewed of thirty-five sampled residents.  The findings included:  Resident #37 was admitted to the facility on December 2, 2011, and readmitted on June 1, 2012, with diagnoses including Congestive Heart Failure, Hypertension, Renal Failure, Insomnia, Anxiety, Alzheimer's Disease, and Hypothyroidism.  Review of a Consultant Pharmacist	F 428	Results obtained will be reported by the Facilities Management Director to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.  F428 1. Resident #37's order to decrease Ativan to 0.25 daily was completed on October 23, 2012. Resident #37 was assessed by the Director of Nursing on October 23, 2012 and found to have no adverse affects. The Director of Nursing notified the physician and the responsible party on October 23, 2012.	11/15/12	

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F 428	<p>Continued From page 14</p> <p>Communication form to the Physician dated September 2012, revealed "Communication/Recommendation...Please consider a trial reduction to Ativan (antianxiety) 0.25 mg qd (every day) x (times) 7 days then d/c (discontinue)..." Continued review of the Consultant Pharmacist Communication form to the Physician dated September 2012, revealed the Nurse Practitioner ordered the Ativan to be decreased to 0.25 mg daily on September 28, 2012.</p> <p>Medical record review of the September 29-30, 2012, and October 1-23, 2012, Medication Administration Record (MAR) revealed the resident continued to receive Ativan 0.5 mg daily.</p> <p>Observation on October 23, 2012, at 3:40 p.m., revealed the resident seated on the side of the bed, talking on the telephone.</p> <p>Interview on October 23, 2012, at 3:20 p.m., with the Director of Nursing (DON), in the DON's office, confirmed the order to decrease the Ativan to 0.25 mg was not followed.</p> <p>Resident #11 was admitted to the facility on June 30, 2012, with diagnoses including Malaise and Fatigue, Hypertension, Vascular Dementia, Gout, Neuropathy, Coronary Atherosclerosis Native Vessel, and Esophageal Reflux.</p> <p>Medical record review of the Pharmacy Consultant Communication to the Nursing Staff dated October 16, 2012, revealed "...Other medications should be given one hour before or two hours after Questran administration..." Continued review of the Consultant Pharmacist</p>	F 428	<p>Resident #11's order to change times of administration of Questran was completed on October 23, 2012. Resident #11 was assessed by the Director of Nursing on October 23, 2012 and found to have no adverse affects. The Director of Nursing notified the physician and the responsible party on October 23, 2012.</p> <p>2. The Director of Nursing and/or Assistant Director of Nursing evaluated all Pharmacy Communication forms and recommendations for the past 3 months on October 31, 2012 to assure all had been addressed by the physician and completed as ordered. No other residents were found to be affected.</p> <p>3. All licensed nurses were inserviced by the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator on October 23 – November 2, 2012 regarding ensuring all Pharmacy Communication forms and recommendations are addressed by the physician and completed as ordered.</p> <p>4. The Director of Nursing, Assistant Director of Nursing and/or Charge Nurse will review all Pharmacy Communication forms and recommendations to assure they are addressed by the physician and completed as ordered daily for 1 week, then 3 times a week for 3 weeks. Then 1 x a week for 2 months and/or 100% compliance.</p>		

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F 428	Continued From page 15 Communication form revealed, "Response: Order written change Questran (1) packet po (by mouth) with fluid or food daily at 11A (a.m.) - 8 pm..."  Medical record review revealed a Physician's Order dated October 17, 2012, "...Change Questran (1) packet with fluid or food po (by mouth) 2 times daily at 8A and 8pm..."  Interview with LPN #1 on October 23, 2012 at 12:30 p.m., at the nurses' station revealed the 8:00 a.m., and 9:00 a.m., medications were given together.  Telephone interview with the Pharmacy Consultant on October 23, 2012, at 1:35 p.m., revealed when Questran is administered with other medications it effects the absorption and the effectiveness of the other medications.  Interview with the Director of Nursing on October 23, 2012 at 1:45 p.m., confirmed the Pharmacy Consultant's recommendations were not followed.	F 428	Results obtained will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	<b>F441</b> 1. The First Crush machine (used to crush residents' medicines) on Hall 200 was cleaned by the Charge Nurse on October 24, 2012.  2. All First Crush machines were evaluated by the Director of Nursing for cleanliness on October 24, 2012. No other machines were found to be affected.  3. All licensed nurses were inserviced by the Director of Nursing, Assistant Director of Nursing and/or the Staff Development Coordinator on October 24 - November 2, 2012 regarding the manufacturer's recommendations for cleaning and the facility policy on cleaning automated pill crushers.	11/15/12	

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F 441	<p>Continued From page 16</p> <p>should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, review of manufacturer's recommendations and interview, the facility failed to ensure a clean environment for the First Crush machine (used to crush resident's medications) for one of four machines observed.</p> <p>The findings included:</p> <p>Observation on October 24, 2012, at 7:40 a.m., on the 200 Hallway medication cart, revealed dried multi-colored debris inside the First Crush</p>	F 441	<p>4. The Director of Nursing, Assistant Director of Nursing or Charge Nurse will evaluate all automated pill crushers for cleanliness after each shift's use daily for 1 week, then 3 times a week for 3 weeks. Then 1 x a week for 2 months and/or 100% compliance.</p> <p>Results obtained will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings by the Director of Nursing for review and recommendations.</p> <p>This committee will determine if any revisions are needed to the audit plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.</p>		

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F 441	Continued From page 17 machine. Further observation revealed inside the lid of the machine "...clean before each use..."  Review of the manufacturer's recommendations "First Crush" revealed "...use a damp or lightly moist paper towel, baby wipe or equivalent to clean unit at the end of each medpass..."  Interview with the Licensed Practical Nurse (LPN) #2, on October 24, 2012, at 7:40 a.m., on the 200 Hallway, confirmed the dried multi-colored debris inside the First Crush machine and the machine had not been cleaned prior to using the machine.  Observation and interview with the Administrator on October 24, 2012, at 7:50 a.m., on the 200 Hallway, confirmed the First Crush machine had dried multi-colored debris and was not clean.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the emergency call light systems in the resident's bathrooms were properly functioning for three of fourteen resident's rooms on one of four hallways.  The findings included:  Observation on October 22, 2012, between 7:45	F 463	<b>F463</b> 1. The emergency call light systems in two resident bathrooms on the 400 Wing Hallway were repaired by Facilities Management Assistant on October 22, 2012.  The emergency call light system in one resident bathroom on the 400 Wing Hallway was repaired by Facilities Management Assistant on October 23, 2012.  2. All emergency call light systems in resident rooms and bathrooms were checked and repaired if necessary to assure proper functioning on October 23, 2012 by the Facilities Management Director and the Facilities Management Assistant.  3. Facilities Management Director and Facilities Management Assistant were inserviced on October 23, 2012 by the Administrator regarding ensuring the emergency call light systems in the resident rooms and bathrooms function properly.	11/15/12

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445476	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/24/2012
NAME OF PROVIDER OR SUPPLIER  ISLAND HOME PARK HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1758 HILLWOOD DRIVE KNOXVILLE, TN 37920	
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F 463	Continued From page 18 a.m. and 8:15 a.m., revealed the emergency call light system in two resident's rooms on the 400 Wing Hallway were not functioning.  Observation and interview with Licensed Practical Nurse (LPN) #1, on October 22, 2012, between 7:45 a.m. and 8:15 a.m., on the 400 Wing Hallway, confirmed the emergency call lights in two resident bathrooms were not functioning.  Observation on October 23, 2012, at 8:29 a.m., revealed the emergency call light in one resident's bathroom on the 400 Wing Hallway was not functioning.  Observation and interview with LPN #1 and the Maintenance Supervisor, on October 23, 2012, at 8:30 a.m., confirmed the emergency call light system in one resident's bathroom on the 400 Wing Hallway was not functioning.	F 463	4. The Facilities Management Director and/or the Facilities Management Assistant will check the emergency call light systems weekly for 4 weeks, then monthly thereafter to assure proper functioning.  Results obtained will be reported by the Facilities Management Director to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIB LE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F514 1. Resident #104 is no longer in the facility.  2. All admitting documentation on residents admitted with wounds in the past 3 months was reviewed by Treatment Nurse November 1-2, 2012 for proper documentation of the skin assessment and wound description in the medical record within 8 hours of admission.	11/15/12

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F 514	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to document the assessment of a pressure sore present on admission, in the medical record for one resident (#104) of thirty-five residents reviewed.</p> <p>The findings included:</p> <p>Resident #104 was admitted to the facility July 21, 2012, with diagnoses including Acute and Chronic Respiratory Failure, Hypertension, Diabetes Mellitus II, Congestive Heart Failure, Chronic Kidney Disease, Iron Deficiency Anemia, and Obstructive Chronic Bronchitis Exacerbation.</p> <p>Medical record review of the Nursing Admission Assessment dated July 21, 2012, revealed "...Skin Condition (check all that apply)..." Option "Thin and fragile" was checked. Continued review of the Nursing Admission Assessment revealed no documentation of the pressure ulcer on the left ear.</p> <p>Interview on October 23, 2012, at 3:00 p.m., in the conference room, with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #2, confirmed LPN #2 had received report of the left ear wound from the transferring facility, a skin assessment was done on admission, and the pressure sore was present on the left ear, but the skin assessment was not documented in the medical record on admission to the facility.</p>	F 514	<p>3. All licensed nurses were inserviced by the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator October 23 – November 2, 2012 on proper documentation of the skin assessment and wound descriptions in the medical record on all new admissions and readmissions within 8 hours of admission.</p> <p>4. The Director of Nursing and/or Assistant Director of Nursing will audit all new admission charts for proper documentation of the skin assessment and wound descriptions in the medical record within 8 hours of admission weekly for 3 months and/or 100% compliance.</p> <p>Results obtained will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan. Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.</p>		

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